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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

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STATEMENT FOR THE RECORD
TO THE
SELECT COMMITTEE ON AGING
UNITED STATES HOUSE OF REPRESENTIVES

Whitefield

ON

RESULTS OF THE GENERAL ACCOUNTING OFFICE'S
ANALYSIS OF THE ECONOMIC VALUE
OF SELECTED MEDICARE SUPPLEMENT AND DREAD DISEASE POLICIES

This statement presents the results of our analysis of the economic value of various health insurance policies individually issued by nine insurance companies. We reviewed four companies' Medicare supplement policies for the elderly and disabled--the so-called Medi-gap insurance--and five companies' dread disease policies, which provide some monetary benefits for individuals or members of their families having cancer. Also, in accordance with the Committee's request, this statement contains our comments on the policy alternatives contained in the Committee's staff report (Comm. Pub. No. 95-160) as they relate to Federal legislation to alleviate the reported abuses in the sale of Medicare supplement insurance policies.

The concept of economic value of health insurance can be subjective because the relative importance individuals place on such protection may differ widely. Also, one of

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the problems in assessing the value of insurance is that its true worth can be influenced by such variables as how an insurer interprets the various exclusions in the policy and other claims payment practices and procedures. This involves information not available to us.

For the purpose of our analysis of the economic value of the selected policies we elected to use the recent loss ratios reported in Annual Statements filed by the insurers with the District of Columbia Commission of Insurance and/or selected State insurance commissions. We used these ratios because they are the only loss ratios generally available to the public, are required by the regulatory authorities in each State, and have well established instructions for computing them.

EXPLANATION OF LOSS RATIOS

It is important to understand what a loss ratio means and what its limitations are. The loss ratio is the proportion of gross premiums which, on the average, is returned to policyholders in the form of benefits. As such, it is an indicator of the economic value of a policy form or forms offered for sale by an insurance company. Loss ratios are generally expressed as percentages. For example, if the loss ratio for a year (or other specified period) were 55 percent, this would mean that total benefits paid to policyholders--

for illnesses originating during the period--would amount to 55 percent of the premiums which they had paid.

The loss ratios specified in the Accident and Health Policy Experience Exhibit of the insurer's Annual Statement are based on losses incurred to premiums earned. A separate ratio is calculated for each individual policy form current as of the statement date. Forms not currently being issued may be grouped together if the earned premiums for each form do not exceed 5 percent of the insurance company's total premiums for individual health insurance.

At the option of the insurer, loss ratios for the Experience Exhibit may be separated into first year and renewals or shown for all years of issue combined. Showing separate ratios can be advantageous to the insurer because first-year loss ratios are generally lower since the insured persons' health has more recently met the company's standards for a new issue. If only combined ratios are shown, fast-growing companies will show up unfavorably in comparison with companies having relatively larger proportions of old business. Using renewal ratios lessens, but does not overcome, the problem of comparing companies with differing proportions of new and old business or of comparing experience on different policies of the same company.

Even though the renewal loss ratio from the Experience Exhibit is not the ideal criterion, it is the one generally

used to measure financial or economic value. One reason for its use is that a loss ratio requires a fairly large volume to be credible. If the data on the overall volume were subdivided by age and sex, the volume in each data cell could be so small that the occurrence of a single fairly large claim could cause the ratio to vary greatly from one cell to another or to vary from one year to another for the same cell.

As stated previously, the Experience Exhibit specifies a ratio based on losses incurred to premiums earned. Losses incurred include not only paid claims but also estimates of liability for (1) claims being settled, (2) claims where illness or hospitalization has occurred but has not ended, thus the total liability is not yet known, and (3) claims where illness or hospitalization has occurred but has not yet been reported to the insurer.

Premiums are payable in advance to cover insured events occurring during a stated period such as a month or a year. Unless there is reason to think otherwise, events giving rise to a claim are assumed to be evenly distributed throughout the period. At the statement date, some or all of the period for which premiums have been paid on each individual policy

will have expired. A pro rata part of the premium is assumed to have been used for losses occurring in the expired portion of the period. The rest of the premium will be held for losses occurring in the unexpired portion. The premium for the expired portion is said to be "earned"; that for the unexpired portion "unearned."

Although the loss ratio is used as a measure of economic value, it does not reflect other factors which should be considered in determining economic value such as:

--What other insurance is available covering the same illness or other contingency?

--Is the individual's financial situation such that he/she can reasonably afford to buy the insurance?

--If an individual has other insurance covering the same contingency, will benefits payable on the new or an existing policy be reduced accordingly under a provision for "coordination of benefits"?

Another aspect concerns quantifying what an acceptable or adequate loss ratio is. There appears to be no general agreement or standard which acceptable loss ratios should meet. The National Association of Insurance Commissioners issued guidelines in June 1978 indicating that minimum acceptable loss ratios range from 40 to 65 percent for individual policies. These ratios, however, are anticipated loss ratios defined as the present value of the expected

benefits to the present value of the expected premiums over the entire period for which coverage is provided. Such ratios may vary for given periods of time from the actual loss ratios reported on the insurer's Experience Exhibit.

The difference in acceptable ratios is due to certain administrative and production expenses which remain relatively constant regardless of type of policy. A policy with limited benefits, therefore, will use a greater proportion of its premiums for expenses, leaving less for benefits.

According to responses to a questionaire sent to the State insurance departments by your Committee, about 20 States have by law or regulation or by internal guidelines established minimum anticipated loss ratios for various classes of health insurance, including Medi-gap policies. These minimum ratios range from 50 to 65 percent for individually issued policies. As best we could determine, the States usually do not systemically followup to compare an insurer's anticipated loss ratio with its actual experience. We understand, however, that in 1978 New Jersey made a special investigation of all forms which had been issued for 5 years or more and withdrew approval if the loss ratio in 1977 (all years of issue combined) was less than 50 percent.

LOSS RATIOS OF POLICIES ANALYZED

We analyzed the economic value of nine companies' individually issued Medi-gap or cancer insurance policies--eight which the Committee specifically requested us to review and one which we selected (with the Committee's approval) because of the significant amount of premiums earned on its cancer insurance policies. Each of the companies Medi-gap or cancer policies had total annual premiums earned in excess of $4.8 million.

In comparison to the range of minimum anticipated loss ratios (50 to 65 percent) mentioned above, we computed for the nine companies' Medi-gap or cancer policies that we could identify aggregate (when more than one policy form was sold) actual loss ratios ranging from 19 to 61 percent. We obtained the loss ratios for each policy form from the Accident and Health Policy Experience Exhibits the companies filed for 1977 or 1976 (the latest available).

The table below shows the aggregate actual loss ratios for the companies' individually issued Medi-gap and cancer insurance policies which we could identify for the year indicated.

Medi-gap	Number of policy forms identified	Premiums earned (millions)	Losses incurred (millions)	Loss ratio (percent)
Reliable Life Ins. Co., Madison, Wis. - 1977	1	$ 6.2	$ 2.2	35
United American Ins. Co., Dallas, Tex. - 1976	3	17.1	6.8	40
Bankers Life and Casualty Co., Chicago, Ill. - 1976	1	9.8	5.9	60
Mutual of Omaha Ins. Co., Omaha, Nebr. - 1976	1	16.8	10.3	61
Cancer				
Union Fidelity Life Ins. Co., Trevose, Penn. - 1976	9	a/4.8	0.9	a/19
Liberty National Life Ins. Co., Birmingham, Ala. - 1977	14	21.3	5.5	26
American Family Life Assurance Co., Columbus, Ga. - 1977	b/8	$ 152.6	$ 64.9	43

	Number of policy forms identified	Premiums earned (millions)	Losses incurred (millions)	Loss ratio (percent)
Colonial Life and Accident Ins. Co., Columbia, S.C. - 1977	5	5.2	2.5	49
Lone Star Life Ins. Co., Dallas, Tex. - 1977	3	9.9	5.5	55

a/One policy form accounted for $4.5 million or 94 percent of the $4.8 million in total premiums earned on the nine policy forms. This policy form reported $3.2 million in premiums earned for the first year with a loss ratio of 13 percent, and $1.3 million in premiums earned for renewals during 1976 with a loss ratio of 37 percent.

b/This number does not include policies no longer issued which the company grouped together for reporting purposes. Of the total premiums earned, $1.6 million is applicable to these policies.

Information on the premiums earned, losses incurred, and loss ratio for each Medi-gap or cancer policy form of the companies which we could identify is attached to this statement. Where shown in the company's Experience Exhibit, we show the loss ratio for the first year and renewals separately.

In late January 1979, American Family Life Assurance Company of Columbus, Georgia, provided us with an actuarial analysis which showed that by recomputing the loss ratios to give recognition to (1) the disproportionate impact of new

policies in recent years and (2) the higher incidence of cancer for older persons, the expected lifetime loss ratios (30 years) for the policies in force ranged from about 55 to 65 percent. The study also showed that about 11 percent of the "new" insured were over 65 years old and that the expected loss ratios for policies issued to persons over age 65 ranged from 67 percent for the first policy-year to 131 percent for 3 or more policy years.

Our actuaries reviewed this report and concluded that it is a useful product and that the computations of expected loss ratios over the estimated life of the policies are theorically justified. However, they had three basic problems with the report.

First, the study deviates from the prescribed format in the Accident and Health Policy Experience Exhibit for computing loss ratios and therefore unless other insurers go through the same exercise, comparisons among companies could not be made.

Second, the study's calculations assume that the policies are noncancellable--that is as long as an individual pays a stated premium amount the insurance will remain in force. In fact, the policies we looked at were guaranteed renewable, but the annual premiums can be increased as long as they are increased for everybody in a given class or jurisdiction.

In this regard, we are aware that in 1978 the company did request and receive a premium increase for a cancer policy for policyholders in the District of Columbia. Therefore, we believe that the study's assumption that the premiums will remain the same over the expected 30-year lifetime of a policy is questionable.

Third, the study does not relate to any particular policy form sold by American Family (such as we were asked to look at), but appears to project the expected loss ratio on a hypothetical set of benefits.

LEGISLATIVE POLICY ALTERNATIVES

The Committee also asked us to look at the policy alternatives contained in its staff report as they relate to Federal legislation to alleviate the reported abuses in the sale of Medicare supplement insurance policies.

One policy alternative, aimed at eliminating beneficiary confusion, would require HEW to issue clear explanations of what Medicare covers. We doubt such a legislative requirement would contribute much to solving the problem. Over the years HEW has provided Medicare beneficiaries with rather comprehensive and clear explanations of the program and we doubt that any publication issued by the Government would eliminate the apparent confusion by Medicare beneficiaries regarding the extent of Medicare coverage.

Our opinion is based, in part, on some work we did several years ago on Medicare's inpatient hospital benefits. Under present law, these benefits are structured around a benefit period or spell of illness. As part of that review we talked to 187 Medicare beneficiaries visiting Social Security district offices in 4 major cities. Of the 187 beneficiaries interviewed, only 2 could identify all of the following principal features of a benefit period:

--That it begins when a beneficiary is first admitted to a hospital.

--That it ends when a beneficiary has been out of a hospital or a facility primarily providing skilled nursing care for 60 consecutive days.

--That 90 days of inpatient hospital care are covered in each benefit period.

Thirty-one beneficiaries identified 1 or 2 of the above features, but 154 (about 80 percent) did not relate any knowledge or understanding of the benefit period.

Only 23 beneficiaries knew that 60 days of inpatient care during a benefit period were covered in full, except for the deductible; 22 knew that co-insurance was chargeable beginning with the 61st day of inpatient hospital care; and only 3 knew of the 60-day lifetime reserve benefit.

We do not know how much Medi-gap insurance is sold based on this lack of knowledge of Medicare coverage, particularly as it relates to the co-insurance features of the Medicare inpatient hospital benefit, but based on the advertising we have seen, this appears to be an important marketing feature. For example, for the 61st through 90th day of hospitalization, the current co-insurance is $40 a day, or a total potential liability of $1,200. For the additional 60 lifetime reserve days, the co-insurance is $80 a day, or a total potential liability of $4,800. These are quite impressive figures, if you are trying to sell insurance, but those familiar with Medicare know that these co-insurance charges rarely come into play.

This brings us to another policy option suggested by the staff report, which is to expand Medicare coverage to close the gaps. Based on our prior work, we estimate that only about 2 percent of the beneficiaries using the inpatient hospital benefit are subject to any daily co-insurance charges and such charges amount to only 1 percent of total Medicare inpatient hospital benefits. Based on 1980 budget estimates, the amount of this co-insurance is about $220 million. If the Congress wanted to absorb this additional

1 percent cost, we believe it would eliminate one source of beneficiary confusion as well as a large potential, but extremely remote, beneficiary liability. On the other hand, if the Congress does not want to absorb this additional cost, a premium charge of $1 a month to each beneficiary would more than cover the value of the inpatient hospital co-insurance.

Another alternative proposed by the staff report involves a voluntary certification program whereby HEW would approve those Medi-gap policies which meet minimum standards in terms of benefits and economic value. In view of the Committee's findings, we can see no valid basis for objecting to this alternative. We suggest, however, if under any legislation economic value is to be expressed in terms of loss ratios or anticipated loss ratios, that HEW's continued approval of Medi-gap policies be subject to the validation of an insurer's actual cumulative experience--say for over a 5-year period.

A fourth alternative involves the enactment of an optional part C of Medicare whereby beneficiaries could buy Medi-gap insurance directly from the Government. We estimate that for fiscal year 1980 the average annual actuarial value of Medicare's deductibles and co-insurance will be about $175 for the elderly and $240 for the disabled.

Under an optional program, however, these amounts are probably understated because we would assume that those individuals with higher than average medical bills would be more likely to participate than those with a history of good health. Although we find this proposal attractive, there are at least two important basic policy questions involved.

First, we believe that there is a question of whether the Government should directly compete with private enterprise, particularly in view of the Committee's study findings which indicate that there are Medi-gap policies, such as Blue Cross/Blue Shield, which return in benefits 90 percent of the money collected in premiums.

Second, is a question of whether the Government should encourage "first dollar" coverage, particularly for the Medicare part B services where cost sharing is generally believed to discourage unnecessary utilization.

A fifth alternative proposes a requirement that all physicians participating in Medicare must take assignment--that is the doctor must accept what Medicare allows as reasonable as the full charge and only charge the beneficiary 20 percent co-insurance on the allowed amount. This proposal addresses the increasingly serious problem under Medicare whereby fewer claims are assigned claims and

the difference between what the doctors charge and Medicare allows is now about 20 percent, which when added to the beneficiaries' co-insurance obligation of 20 percent can present a sizable financial burden. In more absolute terms, in fiscal year 1978, the differences between the doctor charges and the amount allowed as "reasonable charges" on unassigned claims was about $882 million. Many Medi-gap insurance policies do not cover this difference.

We have made various studies of the assignment and related reasonable charge reduction problem for various congressional sources since 1973. Our most recent report, issued in May 1978, concluded that the problem had been studied enough over the years and that the next logical step would be for HEW demonstration projects to test those study results. We proposed legislation to that effect which has not been enacted.

Our reservations concerning legislating mandatory assignments are twofold. First, a study included in the October 1977 issue of Medical Economics featured a survey of a national cross section of office-based physicians. According to the study:

> "The responses made clear that if the option of collecting their full fee directly from Medicare patients is taken away, doctors may desert the program in droves."

The second reservation is based on our work in the Medicaid program where assignment is mandated. In comparison with Medicare, however, few doctors actually participate in Medicaid and of those who do, only a small number receive the bulk of all payments. To illustrate, in six major metropolitan areas throughout the Nation about 40 percent of the physicians received payments under Medicaid, however, only 9 percent of all doctors in those areas accounted for 75 percent of all Medicaid payments. In contrast to the 40 percent participation rate under Medicaid, the survey in Medical Economics showed that 93 percent of the surveyed doctors had Medicare patients.

If mandatory assignment forced Medicare into the Medicaid pattern in terms of physician participation, we simply do not know whether beneficiary dissatisfaction with Medicare would be decreased or increased.

The remaining policy alternatives contained in the staff study appear to involve some sort of Federal regulation of Medi-gap insurance, including a partial repeal of the McCarran-Fergusson Act exemption which generally prohibits Federal agencies from regulating the business of insurance. We would prefer to defer comment on these policy alternatives pending completion of a study for another Committee of Congress involving the broader issues of Federal involvement in regulation of insurance.

RELIABLE LIFE AND CASUALTY COMPANY

MADISON, WISCONSIN

	1977		
	Premiums earned	Losses incurred	Loss ratio
	(000 omitted)		(percent)
Medicare supplement plan II form 634	$ 6,243	$ 2,221	35
Individually issued accident and health insurance other than Medicare supplement insurance	6,927	2,733	39
Total direct business accident and health insurance individually issued	13,170	4,954	38

UNITED AMERICAN INSURANCE COMPANY

DALLAS, TEXAS

	1976		
	Premiums earned	Losses incurred	Loss ratio
	(000 omitted)		(percent)
Medicare supplement policy form MDG:			
First year	--	--	--
Renewal	$ 31	$ 16	51
Medicare companion policy form MCG:			
First year	98	53	54
Renewal	720	432	60
Medicare counterpart policy form MCXC:			
First year	10,590	4,098	39
Renewal	5,638	2,193	39
Total Medicare supplement insurance identified	17,077	6,793	40
Total individually issued accident and health insurance other than Medicare supplement insurance	15,858	8,964	57
Total direct issued accident and health insurance individually issued	32,935	15,757	48

ATTACHMENT

BANKERS LIFE AND CASUALTY COMPANY

CHICAGO, ILLINOIS

	1976		
	Premiums earned	Losses incurred	Loss ratio
	(000 omitted)		(percent)
Medicare supplement policy form GR-764	$ 9,830	$ 5,865	60
Individually issued accident and health insurance other than Medicare supplement insurance	261,194	158,986	61
Total direct business accident and health insurance individually issued	271,024	164,851	61

MUTUAL OF OMAHA INSURANCE COMPANY

OMAHA, NEBRASKA

	1976		
	Premiums earned	Losses incurred	Loss ratio
	(000 omitted)		(percent)
Medicare supplement policy form 50V8	$ 16,829	$ 10,338	61
Individually issued accident and health insurance other than Medicare supplement insurance	339,166	205,107	60
Total direct business accident and health insurance individually issued	355,995	215,445	61

UNION FIDELITY LIFE INSURANCE COMPANY

TREVOSE, PENNSYLVANIA

	1976		
	Premiums earned	Losses incurred	Loss ratio
	(000 omitted)		(percent)
Dread disease policy forms:			
2140 (First year)	$ 3,158	$ 421	13
2140 (Renewal	1,296	483	37
2150 (First year)	12	2	17
2150 (Renewal)	32	7	22
2380 (First year)	76	3	4
2390 (First year)	15	-	-
2410 (First year)	16	5	31
4510 (First year)	34	1	3
4540 (First year	86	5	6
7250 (First year)	43	2	5
7270 (First year)	71	7	10
Total dread disease insurance identified	4,840	936	19
Individually issued accident and health insurance other than dread disease insurance	19,233	10,167	53
Total direct business accident and health insurance individually issued	24,073	11,103	46

LIBERTY NATIONAL LIFE INSURANCE COMPANY

BIRMINGHAM, ALABAMA

	1977		
	Premiums earned	Losses incurred	Loss ratio
	(000 omitted)		(percent)
Cancer expense policy forms:			
7004, 505, and 507	$ 7,046	$ 1,803	26
7003, 506, and 508	2,284	794	35
600 and 579 (I)	7,946	1,980	25
601 and 580 (I)	3,930	893	23
7007	19	3	16
7008	30	1	3
7012	51	4	8
7013	25	13	52
Total cancer insurance identified	21,331	5,491	26
Individually issued accident and health insurance other than cancer insurance	31,147	14,599	47
Total direct business accident and health insurance individually issued	52,478	20,090	38

AMERICAN FAMILY LIFE

ASSURANCE COMPANY OF COLUMBUS

COLUMBUS, OHIO

	1977		
	Premiums earned	Losses incurred	Loss ratio
	(000 omitted)		(percent)
Field issue cancer policy forms:			
FIC-1	$ 4,712	$ 4,379	93
FIC-2 (First year)	690	162	23
FIC-2 (Renewal)	3,009	1,577	52
Cancer policy forms:			
FIC-30M	1,754	1,072	61
CHI-2	43	34	79
A-4474 (First year)	571	161	28
A-4474 (Renewal)	30,974	17,602	57
A-6925 (First year)	9,648	1,723	18
A-6925 (Renewal)	51,242	20,035	39
A-5692 (First year)	3	1	33
A-5692 (Renewal)	651	354	54
A-6886 (First year)	25	4	16
A-6886 (Renewal)	159	55	34
Cancer policy-Japan	47,555	16,370	34
Cancer policies no longer issued-various	1,568	1,330	85
Total cancer insurance identified	152,604	64,859	43
Individually issued accident and health insurance other than cancer insurance	17,062	8,505	50
Total direct business accident and health insurance individually issued	169,666	73,364	43

COLONIAL LIFE AND ACCIDENT

INSURANCE COMPANY

COLUMBIA, SOUTH CAROLINA

	1977		
	Premiums earned	Losses incurred	Loss ratio
	(000 omitted)		(percent)
Cancer benefit rider form R-500	$ 12	$ 2	17
Cancer policy form 0124	2,158	1,055	49
Cancer policy-surgical schedule-form 0610	2,598	1,315	51
Cancer expense form 0797	379	139	37
Cancer expense form 0823	19	-	-
Total cancer insurance identified	5,166	2,511	49
Individually issued accident and health insurance other than cancer insurance	46,780	20,429	44
Total direct business accident and health insurance individually issued	51,946	22,940	44

LONE STAR INSURANCE COMPANY

DALLAS, TEXAS

	1977		
	Premiums earned	Losses incurred	Loss ratio
	(000 omitted)		(percent)
Cancer idemnity policy form GR3-056	$ 4,271	$ 2,468	58
Cancer policy amendment forms SPCGR-100 and 101	5,639	3,030	54
Total cancer insurance identified	9,910	5,498	55
Individually issued accident and health insurance other than cancer insurance	25,741	13,509	52
Total direct business accident and health insurance individually issued	35,651	19,007	53